San Bernardino County In-Home Supportive Services Public Authority
600 North Arrowhead Avenue Ste.100
San Bernardino, CA 92415-0034
Toll Free Phone (866) 985-6322 • Fax (909) 386-3072

CLIENT REGISTRY APPLICATION

IF YOU NEED HELP FILLING OUT THIS FORM, PLEASE TELEPHONE US.
(Please print)

NAME: _____ DATE: _____

STREET ADDRESS: _____

CITY: _____, CA ZIP CODE: _____

PHONE: (_____) _____ MESSAGE PHONE: (_____)_____

EMAIL: _____

IHSS SOCIAL WORKER'S NAME: _____

Emergency Contact:

Name:	**Relationship:**
Address:	**Telephone:**

My Primary language is: _____ **My Secondary language is:**_____

I am authorized by my NOA to receive _____ **IHSS service hours per month.**

I currently have a Provider *(Check one)*: ☐ YES ☐ NO

I need a Provider *(Check one)*: ☐ On a temporary basis from _____to_____

☐ A permanent Provider beginning _____

For which services are you authorized? *(Check all that apply.)*

- ☐ Ambulation/Transfers
- ☐ Bathing
- ☐ Bed Baths
- ☐ Bowel and Bladder Care
- ☐ Care and Assistance with Prosthesis
- ☐ Changing/Making Bed
- ☐ Dressing
- ☐ Errands
- ☐ Feeding
- ☐ Grooming
- ☐ Housekeeping
- ☐ Light Laundry
- ☐ Meal Preparation
- ☐ Menstrual Care
- ☐ Protective Supervision
- ☐ Remove Ice/Snow
- ☐ Repositioning and skincare
- ☐ Transport To:
  - ☐ Medical Appointments
  - ☐ Shopping
  - ☐ Other
- ☐ Wheelchair Assistance

Are you authorized to receive: *(Check all that apply)*

☐ Administration of Oral Medication ☐ Assistance with Respirator

☐ Assistance with Administration of Insulin ☐ Wound Care

☐ Other _____

The days and hours I prefer to receive services are: *(Please check all that apply)*

☐ Morning	☐ Sun	☐ Mon	☐ Tue	☐ Wed	☐ Thu	☐ Fri	☐ Sat
☐ Afternoon	☐ Sun	☐ Mon	☐ Tue	☐ Wed	☐ Thu	☐ Fri	☐ Sat
☐ Evening	☐ Sun	☐ Mon	☐ Tue	☐ Wed	☐ Thu	☐ Fri	☐ Sat
☐ Overnight	☐ Sun	☐ Mon	☐ Tue	☐ Wed	☐ Thu	☐ Fri	☐ Sat

What are your preferences regarding a provider? *(Check all that apply. Preferences should reflect service needs.)*

☐ Male ☐ Female ☐ No Gender Preference

☐ Same Primary Language ☐ Sign Language

☐ Driver's License

Terms of Use and Release of Information

I understand that the information contained on this application is intended for the exclusive use of the San Bernardino County In-Home Supportive Services Public Authority (Public Authority) for the purpose of providing me a list of referrals of qualified IHSS Providers. I authorize the Public Authority to verify authorized hours and services with the Department of Aging and Adult Services IHSS Program. I understand that my use of Registry Services does not commit me to hiring any individual referred by the Public Authority, nor does it imply a guarantee of satisfaction with the persons referred. I understand that I retain the right to hire, fire and supervise the work of any IHSS Provider referred to me by the Public Authority.

_____ _____

Client Signature Date

IF SOMEONE ASSISTED YOU IN COMPLETED THIS APPLICATION, PLEASE COMPLETE THIS SECTION

ASSISTANCE IN COMPLETING THIS APPLICATION WAS PROVIDED BY:

NAME:	SIGNATURE:	DATE: